		FOR OHF USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033779

Facility Name: Covenant Health Care Center-Northbrook

Address: 2155 Pfingsten Road (Number) Northbrook (City) 60062 (Zip Code)

County: Cook

Telephone Number: (847) 480-6380 **Fax #** (847) 480-7666

IDPA ID Number: 52-1115873001

Date of Initial License for Current Owners: 01/20/72

Type of Ownership:

[X] VOLUNTARY,NON-PROFIT		[ ] PROPRIETARY		[ ] GOVERNMENTAL	
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501(c)(3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Barry C. Scutillo, CPA **Telephone Number:** (954) 721-5222

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/99 to 01/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Richard W. Olson

(Title) Vice-President, Finance

Paid Preparer

(Signed) See Attached Accountants Report (Date)

(Print Name and Title) Scutillo & Blake, CPA, PA

(Firm Name & Address) 8000 N. University Drive, Ft. Lauderdale, Fl 33321

(Telephone) (954) 721-5222 Fax # (954) 722-6692

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	64	Sheltered Care (SC)	64	23,360	5
6		ICF/DD 16 or Less			6
7	166	TOTALS	166	60,590	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,875	27,216	1,910	34,001	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		19,229		19,229	12
13	DD 16 OR LESS					13
14	TOTALS	4,875	46,445	1,910	53,230	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.85%

D. How many bed-hold days during this year were paid by Public Aid?
9 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 01/20/72

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1910

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 01/31/00 Fiscal Year: 01/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	394,577	53,762	569	448,908		448,908	0	448,908			1
2	Food Purchase		361,168		361,168		361,168	0	361,168			2
3	Housekeeping	172,754	24,471	25,247	222,472		222,472	0	222,472			3
4	Laundry	18,608	17,765	88,139	124,512		124,512	0	124,512			4
5	Heat and Other Utilities			217,547	217,547		217,547	0	217,547			5
6	Maintenance	80,599	20,791	199,664	301,054		301,054	(8,276)	292,778			6
7	Other (specify):*							0				7
8	TOTAL General Services	666,538	477,957	531,166	1,675,661		1,675,661	(8,276)	1,667,385			8
	B. Health Care and Programs											
9	Medical Director			19,761	19,761		19,761	0	19,761			9
10	Nursing and Medical Records	2,054,069	79,691	23,655	2,157,415		2,157,415	0	2,157,415			10
10a	Therapy	104,759	1,755	96,518	203,032		203,032	0	203,032			10a
11	Activities	164,604	2,942	125,586	293,132		293,132	0	293,132			11
12	Social Services	57,416	515	280	58,211		58,211	0	58,211			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	2,380,848	84,903	265,800	2,731,551		2,731,551		2,731,551			16
	C. General Administration											
17	Administrative	126,699		321,636	448,335	(8,456)	439,879	207,789	647,668			17
18	Directors Fees							0				18
19	Professional Services			78,722	78,722		78,722	0	78,722			19
20	Dues, Fees, Subscriptions & Promotions			21,750	21,750		21,750	(3,676)	18,074			20
21	Clerical & General Office Expenses	172,370	20,883	167,652	360,905		360,905	0	360,905			21
22	Employee Benefits & Payroll Taxes			597,007	597,007	8,456	605,463	0	605,463			22
23	Inservice Training & Education							0				23
24	Travel and Seminar			15,249	15,249		15,249	(9,510)	5,739			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			15,732	15,732		15,732	(449)	15,283			26
27	Other (specify):*							0				27
28	TOTAL General Administration	299,069	20,883	1,217,748	1,537,700		1,537,700	194,154	1,731,854			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,346,455	583,743	2,014,714	5,944,912		5,944,912	185,878	6,130,790			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			447,425	447,425		447,425	(181,482)	265,943			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			363,167	363,167		363,167	(363,167)				32
33	Real Estate Taxes							0				33
34	Rent-Facility & Grounds			525	525		525	0	525			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	TOTAL Ownership			811,117	811,117		811,117	(544,649)	266,468			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		329,973	23,688	353,661		353,661	0	353,661			39
40	Barber and Beauty Shops	29,998		1,018	31,016		31,016	0	31,016			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee							69,768	69,768			42
43	Other (specify):*			55,841	55,841		55,841	(19,629)	36,212			43
44	TOTAL Special Cost Centers	29,998	329,973	80,547	440,518		440,518	50,139	490,657			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,376,453	913,716	2,906,378	7,196,547	0	7,196,547	(308,632)	6,887,915			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 **Report Period Beginning:** 02/01/99 **Ending:** 01/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(181,482)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(372,769)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,676)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(28,262)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (586,189)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	207,789	17	34
35	Other- Attach Schedule **Participation Fee**	69,768	42	35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 277,557		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (308,632)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Preview

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5A**

Facility Name Covenant Health Care Center-Northbrook
ID# 0033779
Report Period Beginning: 02/01/99
Ending: 01/31/00

To Print the Other Adjustments you have entered.

1. Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.
2. Push the Print Other Adjustments button.

Print Other Adjustments

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	0
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	0	0	Line 4	0
5	Telephone, TV & Radio in Resident Rooms	0	0	Line 5	0
6	Rented Facility Space	0	0	Line 6	(8,276)
7	Sale of Supplies to Non-Patients	0	0	Line 7	0
8	Laundry for Non-Patients	0	0	Line 8	(8,276)
9	Non-Straightline Depreciation	(181,482)	30	Line 9	0
10	Interest and Other Investment Income	0	0	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	0	0	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13	Sales Tax	0	0	Line 12	0
14	Non-Care Related Interest	(372,769)	32	Line 13	0
15	Non-Care Related Owner's Transactions	0	0	Line 14	0
16	Personal Expenses (Including Transportation)	0	0	Line 15	0
17	Non-Care Related Fees	0	0	Line 16	0
18	Fines and Penalties	0	0	Line 17	0
19	Entertainment	0	0	Line 18	0
20	Contributions	0	0	Line 19	0
21	Owner or Key-Man Insurance	0	0	Line 20	(3,676)
22	Special Legal Fees & Legal Retainers	0	0	Line 21	0
23	Malpractice Insurance for Individuals	0	0	Line 22	0
24	Bad Debt	0	0	Line 23	0
25	Fund Raising, Advertising and Promotional	(3,676)	20	Line 24	(9,510)
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	(449)
28	Yellow Page Advertising	0	0	Line 27	0
29	Non-Paid Workers	0	0	Line 28	(13,635)
30	Donated Goods	0	0	Line 29	(21,911)
31	Amortization Expense	0	0	Line 30	(181,482)
32	Non allowable travel & seminar	(9,510)	24	Line 31	0
33	Property Taxes - Rental	(10,290)	43	Line 32	(363,167)
34	Motor Vehicle Expense	(2,636)	6	Line 33	0
35	Auto Insurance	(449)	26	Line 34	0
36	Amortization - Loss on Debt	9,602	32	Line 35	0
37	Maintenance Costs Deferred	(14,525)	6	Line 36	0
38	Amortization of Deferred Maint Costs	8,885	6	Line 37	(544,649)
39	Provider Participation Fee	69,768	42	Line 38	0
40	Employee Recognition	(9,339)	43	Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	69,768
44				Line 43	(19,629)
45				Line 44	50,139
46				Line 45	(516,421)
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1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43	

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Covenant Health Care Center-Northbrook **#** 0033779 **Report Period Beginning:** 02/01/99 **Ending:** 01/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(8,276)	0	0	0	0	0	0	0	0	0	0	(8,276)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,276)	0	0	0	0	0	0	0	0	0	0	(8,276)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	207,789	0	0	0	0	0	0	0	0	0	207,789	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(3,676)	0	0	0	0	0	0	0	0	0	0	(3,676)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(9,510)	0	0	0	0	0	0	0	0	0	0	(9,510)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(449)	0	0	0	0	0	0	0	0	0	0	(449)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13,635)	207,789	0	0	0	0	0	0	0	0	0	194,154	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(21,911)	207,789	0	0	0	0	0	0	0	0	0	185,878	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(181,482)	0	0	0	0	0	0	0	0	0	0	(181,482)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(363,167)	0	0	0	0	0	0	0	0	0	0	(363,167)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(544,649)	0	0	0	0	0	0	0	0	0	0	(544,649)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	69,768	0	0	0	0	0	0	0	0	0	0	69,768	42
43	Other (specify):*	(19,629)	0	0	0	0	0	0	0	0	0	0	(19,629)	43
44	**TOTAL Special Cost Centers**	50,139	0	0	0	0	0	0	0	0	0	0	50,139	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(516,421)	207,789	0	0	0	0	0	0	0	0	0	(308,632)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Retirement Comm., Inc.	100.00	See Attached List	Various	Cov. Retire. Comm.	Chicago	Mgt Services

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V		17	Management Fees	$ 321,636	Covenant Retirement Communities, Inc.	100.00%	$ 529,425	$ 207,789	1	207789
2	V		19	Professional Services	62,928	Covenant Retirement Communities, Inc.	100.00%		(62,928)	2	-62928
3	V			Detail:						3	
4	V		19	Audit Services				11,213	11,213	4	11213
5	V		19	Data Processing				17,688	17,688	5	17688
6	V		19	Cost Report Preparation				5,496	5,496	6	5496
7	V		19	Payroll Processing				9,245	9,245	7	9245
8	V		19	Legal Services				876	876	8	876
9	V		19	Ethics Committee				160	160	9	160
10	V		19	Therapy Consulting				18,250	18,250	10	18250
11	V		22	Pension Expense	51,206		100.00%	51,206		11	
12	V									12	
13	V									13	
14	Total				$ 435,770			$ 643,559	$ * 207,789	14	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Covenant Retirement Communities, Inc.
Street Address: 5115 North Francisco Avenue, Suite 200
City / State / Zip Code: Chicago, Illinois 60625
Phone Number: (773) 878-2294
Fax Number: (773) 878-2289

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Management Fees	Actual Net Svc Rev	88,309,000	32	$ 4,237,752	$ 1,522,495	6,702,458	$ 321,636	1
2	19	Audit Services	Fixed Fee Per Mo. (1)	32	32	245,674	0	1	11,213	2
3	19	Data Processing	Fixed Fee Per Mo. (2)	32	32	305,652	0	1	17,688	3
4	19	Cost Report Preparation	Fixed Fee Per Mo. (3)	14	14	55,968	0	1	5,496	4
5	19	Ethics Committe	Direct Cost	1	1	160	Not Available	1	160	5
6	22	Pension Expense	Fixed Fee Per Mo. (4)	32	32	479,364	0	1	51,206	6
7	19	Payroll Processing	Fixed Fee Per Mo. (5)	32	32	9,245	0	1	9,245	7
8	19	Legal Fees	Direct Cost	1	1	876	0	1	876	8
9	22	Therapy Consulting	Direct Cost	1	1	18,250	Not Available	1	18,250	9
10										10
11										11
12										12
13										13
14		NOTE:								14
15		1) Audit services are based upon a fixed fee of $934 / month. The G/L is adjusted at year end to reflect actual expense								15
16		2) Data processing is based on a fixed fee of $1,474 /month.								16
17		3) Medicare cost report preparation is based upon a fixed fee of $458 / month.								17
18		4) Pension plan expense is based on a fixed fee of $4,267 / month.								18
19		5) Payroll processing is based on a fixed fee of $770 / month.								19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,352,941	$ 1,522,495		$ 435,770	25

Print Preview

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Senior Secured Notes		X	Refinance of Debt		02/01/93	$ 780,600	$ 338,400	08/01/02	Variable	$ 37,937	1
2	Interest-1992 Tax T Bonds		X	Refinance of Debt		02/01/93	1,898,492	1,221,203	12/01/15	Variable	92,811	2
3	Interest-1992 Tax 5 Y Bonds		X	Refinance of Debt		02/01/93	2,226,827	2,226,831	12/01/15	Variable	116,909	3
4												4
5	See Attached Schedule		X	Refinance of Debt		01/28/98	1,391,331	1,101,179	01/28/15	Variable	60,806	5
	Working Capital											
6	Interco notes to/from CRC			Working Capital		02/01/95	(6,217,334)	(3,716,451)	N/A	Variable		6
7	Interco notes			Working Capital		02/01/95	(2,925,000)	(2,904,000)	N/A	5.00%		7
8	Amortization of C.O. financing										54,704	8
9	TOTAL Facility Related						$	$			$ 363,167	9
	B. Non-Facility Related*											
10												10
11	Interest-See Attached Schedule										(372,769)	11
12												12
13	Add: Amort loss on EE of debt										9,602	13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 363,167	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 77,894 B. General Construction Type: Exterior Brick - Masonary Frame Steel Studded Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Covenant Village of Northbrook Residential Independent Living Facility 302,869 sq. ft., 306 units.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1973	$ 70,272	1
2					2
3	TOTALS			$ 70,272	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	166		1974	1974	$ 1,467,406	$ 36,685	40	$ 36,685	$	$ 972,157	4
5			1975	1975	2,250	56	40	56		1,434	5
6			1976	1976	1,916	48	40	48		1,206	6
7			1977	1977	2,769	69	40	69		1,627	7
8			1978	1978	7,643	191	40	191		4,299	8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Building Improvements - Brandel Care Center			1979	18,220	455	40	455		9,793	9
10				1980	20,844	521	40	521		10,683	10
11				1981	38,116	953	40	953		18,582	11
12				1982	3,360	84	40	84		1,554	12
13				1984	13,999	350	40	350		5,775	13
14				1985	162,076	4,052	40	4,052		62,682	14
15				1986	36,791	978	40	978		13,129	15
16				1987	17,303	433	40	433		5,839	16
17				1988	30,032	751	40	751		9,385	17
18				1989	472,871	11,822	40	11,822		135,950	18
19				1989	115,230	2,881	40	2,881		30,248	19
20				1990	77,922	1,948	40	1,948		18,506	20
21				1991	25,051	626	40	626		5,323	21
22				1992	7,901	198	40	198		1,482	22
23				1994	19,938	498	40	498		3,240	23
24	52 pair of shear and rods - all patient rooms			1997	8,000	200	40	200		800	24
25	14 Cubicle Curtains - wings 100 and 200			1997	2,636	66	40	66		264	25
26	A/C Equipment			1998	3,549	89	40	89		222	26
27	Room Remodeling			1999	2,989	75	40	75		112	27
28	Window Treatments			1999	29,864	747	40	747		1,120	28
29	Heating A/C work			1999	1,665	42	40	42		63	29
30	New Light Fixtures			1999	1,647	41	40	41		63	30
31	Hall Door Replacement			1999	329	8	40	8		12	31
32	Roof Repair/Replacement			1999	133,950	3,349	40	3,349		5,023	32
33	New Bathrooms			1999	9,685	242	40	242		363	33
34	Renovation/Modernization			2000	4,013,267	50,165	40	50,165		50,165	34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 118,623		$ 118,623	$	$ 1,371,101	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	166				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Building Improvements - Axelson Manor			1987	9,537	238	40	238		3,219	9
10				1988	11,898	297	40	297		3,718	10
11				1989	25,256	631	40	631		7,261	11
12				1990	6,612	165	40	165		1,736	12
13				1991	5,581	140	40	140		1,326	13
14				1992	10,312	258	40	258		2,191	14
15				1993	10,084	252	40	252		1,891	15
16				1994	11,446	286	40	286		1,860	16
17				1995	4,965	124	40	124		683	17
18	Padding and Carpeting			1996	3,410	85	40	85		384	18
19	Drapes & Shares			1996	1,857	46	40	46		208	19
20	Carpet			1997	11,718	293	40	293		1,025	20
21	Food Service Renovations			1997	5,951	149	40	149		521	21
22	New Building			1998	2,060,269	51,508	40	51,508		128,767	22
23	New Carpet			1998	6,817	170	40	170		255	23
24	Drapes/Shears for Rooms			1998	554	14	40	14		21	24
25	New Roof			1998	38,000	950	40	950		1,426	25
26	Additional Construction			1998	72,323	1,809	40	1,809		2,714	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 57,415		$ 57,415	$	$ 159,206	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	166				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Land Improvements			1980	402	10	20	10		402	9
10				1981	925	46	20	46		902	10
11				1982	14,374	719	20	719		13,299	11
12				1985	27,727	1,386	20	1,386		21,871	12
13				1989	1,500	75	20	75		862	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 2,236		$ 2,236	$	$ 37,336	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 715,483	$ 245,968	$ 64,486	$ (181,482)	10	$ 406,931	37
38	Current Year Purchases	461,932	23,183	23,183		10	23,298	38
39	Fully Depreciated Assets	393,896	0	0		10	393,896	39
40								40
41	TOTALS	$ 1,571,311	$ 269,151	$ 87,669	$ (181,482)		$ 824,125	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resd. trans., maint.	Bus-1987	1987	$ 32,205	$	$	$	4	$ 32,205	42
43	Resident Transportation	Bus-1993	1993	44,392				5	44,392	43
44	Resident Transportation	Bus-1993	1993	24,033				5	24,033	44
45	Maintenance	Truck	1993	22,456				5	22,456	45
46	TOTALS			$ 123,086	$	$	$		$ 123,086	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 447,425	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 265,943	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (181,482)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,514,854	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Non-care Vehicles	$ 24,339	$	$ 24,339	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 24,339	$	$ 24,339	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	$	302	$ 16,214	$	302	$ 16,214	1
2	Licensed Speech and Language Development Therapist	10a	hrs		59	3,593		59	3,593	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		772	43,125		772	43,125	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts		15,852		325,736	15,852	325,736	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): X-Ray/Lab	39		By Patient	665		3,692	665	3,692	13
14	TOTAL			$	17,649	$ 62,932	$ 329,428	17,649	$ 392,360	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 01/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 120,351	$ 11,692,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	252,383	8,441,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		11,922,000	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,001	576,000	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 374,735	$ 32,631,000	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,162,116	100,762,000	12
13	Land	502,095	17,927,000	13
14	Buildings, at Historical Cost	10,782,057	282,590,000	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,431,591	37,334,000	16
17	Accumulated Depreciation (book methods)	(3,590,049)	(119,939,000)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		71,342,000	21
22	Other Long-Term Assets (specify):	1,538,217	20,857,000	22
23	Other(specify): Construction In Progress		32,874,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,826,027	$ 443,747,000	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,200,762	$ 476,378,000	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 314,162	$ 8,757,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		7,810,000	28
29	Short-Term Notes Payable		4,685,000	29
30	Accrued Salaries Payable	294,865	4,449,000	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,115		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	61,240	1,737,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	10,800	7,160,000	36
37	Current Maturities - Long Term Debt	198,717	5,390,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 907,899	$ 39,988,000	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,785,613	203,838,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Accts, Other Liabilities	(6,488,418)	7,913,000	43
44	Deferred Revenue		160,952,000	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (1,702,805)	$ 372,703,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (794,906)	$ 412,691,000	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 12,995,668	$ 63,687,000	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,200,762	$ 476,378,000	48

***(See instructions.)**

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Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,881,020	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,881,020	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,103,469	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Designated Contributions - Plant**	11,407	15
16	Other (describe) **Planned Giving Assessments**	(228)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,114,648	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 12,995,668	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,129,680	1
2	Discounts and Allowances for all Levels	(605,669)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,524,011	3
	B. Ancillary Revenue		
4	Day Care	173,677	4
5	Other Care for Outpatients		5
6	Therapy	479,296	6
7	Oxygen	4,700	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 657,673	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	44,867	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	352,528	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,595	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	50,504	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 454,494	23
	D. Non-Operating Revenue		
24	Contributions	78,355	24
25	Interest and Other Investment Income***	552,593	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 630,948	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other Non Operating Revenue	32,885	28
28a	Rounding	5	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 32,890	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,300,016	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 1,675,661	31
32	Health Care	2,731,551	32
33	General Administration	1,537,700	33
	B. Capital Expense		
34	Ownership	811,117	34
	C. Ancillary Expense		
35	Special Cost Centers	440,518	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,196,547	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,103,469	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,103,469	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,690	2,008	$ 63,388	$ 31.57	1
2	Assistant Director of Nursing	2,242	2,842	48,455	17.05	2
3	Registered Nurses	29,958	32,053	714,231	22.28	3
4	Licensed Practical Nurses	1,879	2,095	33,088	15.79	4
5	Nurse Aides & Orderlies	93,406	104,250	1,162,410	11.15	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,864	5,179	104,759	20.23	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,448	2,654	29,164	10.99	9
10	Activity Assistants	13,771	14,494	121,810	8.40	10
11	Social Service Workers	3,811	4,134	57,416	13.89	11
12	Dietician					12
13	Food Service Supervisor	5,667	6,502	109,572	16.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,561	33,296	285,005	8.56	15
16	Dishwashers					16
17	Maintenance Workers	6,554	6,991	80,599	11.53	17
18	Housekeepers	17,363	19,394	172,754	8.91	18
19	Laundry	1,741	2,050	18,608	9.08	19
20	Administrator	3,062	3,568	126,541	35.47	20
21	Assistant Administrator					21
22	Other Administrative	1,991	2,095	27,911	13.32	22
23	Office Manager					23
24	Clerical	12,615	13,887	144,616	10.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	900	1,120	14,392	12.85	31
32	Other Health Care(specify)					32
33	Other(specify)	4,339	4,783	61,734	12.91	33
34	TOTAL (lines 1 - 33)	238,862	263,395	$ 3,376,453 *	$ 12.82	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	65	$ 2,280	1,3	35
36	Medical Director	Monthly	19,761	9,3	36
37	Medical Records Consultant	384	10,922	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,911	10,3	39
40	Physical Therapy Consultant	Monthly	33,171	10a, 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	415	10a, 3	43
44	Activity Consultant	88	2,470	11,3	44
45	Social Service Consultant	6	150	12,3	45
46	Other(specify)				46
47	Utilization Review	Annual	1,500	10,3	47
48					48
49	TOTAL (lines 35 - 48)	543	$ 72,580		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides	N/A			52
53	TOTAL (lines 50 - 52)		$		53

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Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Barbara Meuller	Administrator	0.00%	$ 54,085
Bob Edlen	Administrator	0.00%	9,817
Neil Warnygora	Administrator	0.00%	54,341
Employee Benefits			8,456
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 126,699

B. Administrative - Other

Description	Amount
Covenant Retirement Communities, Inc	$
Management Services	321,636
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 321,636

C. Professional Services

Vendor/Payee	Type	Amount
Deloitte & Touche, CPA	Audit Services	$ 11,213
ADP	Payroll Services	9,245
Covenant Retirement Comm.	Data Processing	17,688
Covenant Retirement Comm.	Legal Services	876
Seabury & Smith	Benefits Consulting	6,051
Compudata	Survey	174
Center for Ethics	Ethics Committee Cons.	160
Scutillo & Blake	Cost Report Preparation	5,496
Heritage Therapy	Therapy Consulting	18,250
Dynamic People/Olstens	Temporary Employees	8,631
Other		938
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 78,722

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,168
Unemployment Compensation Insurance	6,185
FICA Taxes	241,528
Employee Health Insurance	267,616
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	4,549
Pension Plan Expense	51,206
Other	755
Reclass of Administrator Emp Benefits	8,456
TOTAL (agree to Schedule V, line 22, col.8)	$ 605,463

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,031
Health Care Worker Background Check (Indicate # of checks performed)	
Dues and Subscriptions	9,979
Promotion/Public Relations	2,740
Less: Non allowable dues/subs	(936)
Less: Public Relations Expense	(2,740)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,074

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,172
Less: Out-of-State Travel	(2,172)
In-State Travel	6,076
Less: Non allowable travel	(2,590)
Seminar Expense	7,001
Less: Non allowable seminar exp	(4,748)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,739

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Interior Repainting	03/96	$ 624	3	$ 191	$ 208	$ 208	$ 17	$	$	$	$	$
2	Interior Repainting	08/96	936	3	156	312	312	156					
3	Interior Repainting	10/96	432	3	48	144	144	96					
4	Interior Repainting	11/96	2,520	3	210	840	840	630					
5	Interior Repainting	12/96	1,344	3	75	448	448	373					
6	Interior Repainting	01/97	1,200	3	33	400	400	367					
7	Interior Repainting	03/97	408	3		125	136	136	11				
8	Interior Repainting	06/97	805	3		179	268	268	90				
9	Interior Repainting	07/97	860	3		167	287	287	119				
10	Interior Repainting	08/97	1,604	3		267	535	535	267				
11	Interior Repainting	09/97	1,110	3		154	370	370	216				
12	Interior Repainting	10/97	805	3		90	268	268	179				
13	Interior Repainting	11/97	815	3		68	272	272	203				
14	Interior Repainting	12/97	610	3		34	203	203	170				
15	Interior Repainting	01/98	585	3		16	195	195	179				
16	Heating Unit Repair	03/97	2,212	3		676	737	737	62				
17	Interior Repainting	12/98	6,174	3			172	2,058	2,058	1,886			
18	See Schedule	FY2000	14,525					1,917	4,842	4,842	2,924		
19													
20	TOTALS		$ 37,569		$ 713	$ 4,128	$ 5,795	$ 8,885	$ 8,396	$ 6,728	$ 2,924	$	$

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Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02/01/99 Ending: 01/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **34,936** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **69,768**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **15,727**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0 %**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Deloitte & Touche, CPA** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

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